

1 patient, whether it's any medical intervention at
2 all or some combination of medication, surgery, and
3 mental health support.

4 Q So if orchiectomy and hormone therapy have
5 essentially the same effect on the circulating
6 hormones of a transfeminine patient, is it true
7 that the only advantage of surgery is that it
8 removes the site of the testicles?

9 A So I can't discuss the impact. While I work with
10 endocrinologists and medical people, the management
11 of hormones and hormone levels is not something
12 that I do in my practice.

13 Q Is vulvoplasty in transfeminine patients a cosmetic
14 surgery?

15 A No. Well, again assuming appropriate assessment
16 and if we can assume for the question that they've
17 been appropriately diagnosed, assessed, et cetera.

18 Q Yes, we can assume those things. So why is it not
19 a cosmetic surgery?

20 A Well, people may choose vulvoplasty, which refers
21 to the construction of the clitoral and vulvar
22 structures without the construction of a vaginal
23 canal for a number of reasons. One, certainly
24 perhaps most commonly, is medical risk. We've
25 talked about some conditions that may impact

1 surgery. Pelvic radiation or prostatectomy, for
2 example, may make the risk of development or
3 construction of a vaginal canal -- the risks of
4 that -- the risks of constructing a vaginal canal
5 in a person who's had pelvic radiation or
6 prostatectomy may be excessively high, and so they
7 may opt for very rational reasons to have a
8 vulvoplasty. They may not be people who are
9 engaged in receptive vaginal intercourse and may
10 choose to lower operative recovery times or risks
11 and undergo a vulvoplasty. They may have other
12 medical conditions that preclude their ability to
13 dilate. I've had patients with cerebral palsy or
14 multiple sclerosis. We've discussed aftercare
15 requirements, and reasons assessing aftercare
16 recommendations are important. And so if we know a
17 person cannot participate in the aftercare or
18 perform some of the necessary functions, for
19 example, like dilation following a vaginoplasty
20 that a vulvoplasty may be a reasonable alternative.

21 Q Well, let me ask it this way: What specific
22 purpose does vulvoplasty serve?

23 A Again, similar to vaginoplasty, it's alignment of
24 one's body with their identity for treatment of the
25 medical condition gender dysphoria.

1 Q So it's providing a certain aesthetic appearance of
2 the genitals?

3 A No. As with plastic surgery and nature, we always
4 consider both form and function. So regardless of
5 whether we're operating for cancer, trauma,
6 infection, genital conditions we're always mindful
7 of aesthetics, but aesthetics are not the only
8 driver here. In fact, it's the treatment of the
9 serious medical condition of general dysphoria and
10 the congruence that the gender-affirming surgery
11 provides between one's body and their identity that
12 it's considered medically necessary and in that
13 sense reconstructive.

14 Q So the function of vulvoplasty is alleviating
15 gender dysphoria by changing the appearance of the
16 genitals?

17 A It is alleviation or relief of dys- -- of dysphoria
18 by providing congruence between one's body and
19 their identity.

20 Q Okay. Is facial feminization surgery for
21 transfeminine patients cosmetic?

22 A Again, it would depend upon the particular patient
23 and the procedure.

24 Q What about facial feminization surgery for
25 cisgender women? Is that cosmetic?

1 A Again, so let's take, for example, a facelift or a
2 procedure that accompanies a facelift. We can
3 obviously say that as, let's say, we're older and
4 we've got skin laxity and so forth and we desire to
5 be rejuvenated that that's cosmetic. However, we
6 may have people who are affected by a tumor, trauma
7 or nerve injury where their skin sags and an
8 analogous procedure, a similar facelift would be
9 performed, and that would be reconstructive in
10 nature. So to answer your question, it would
11 depend upon the person, it would depend upon the
12 procedure, and it would depend upon the dia- -- the
13 condition.

14 Q So if I'm understanding you, for cisgender women,
15 whether a facial feminization surgery is
16 reconstructive depends on some pathology or disease
17 or diagnosis?

18 A Well, you're using the term facial feminization
19 which is not necessarily a term. If you can be
20 more specific as to a procedure, I may be able
21 to --

22 Q A facelift.

23 A Again, it would depend upon the condition for which
24 it's performed. A transgender woman may have a
25 face- -- facelift from tumor or removal of a tumor

1 that caused facial drooping. A cisgender woman
2 might have that. A transgender women might require
3 suspension of the soft tissues of her face
4 following what we would typically call a facial
5 feminization procedure, manipulation of her bony
6 skeleton, for example, in which case that would
7 often be considered reconstructive or medically
8 necessary.

9 Q All right. And the last one -- the last procedure
10 I wanted to ask you about, in paragraph 30 of your
11 report you mentioned liposuction. When is
12 liposuction for transfeminine women -- is that
13 cosmetic?

14 A Again, it would depend upon the particular of the
15 case.

16 Q What does it depend on?

17 A It would depend upon why we're performing
18 liposuction. As you see, I say liposuction and
19 lipofilling. So that may be used to augment the
20 breasts in which case it may be considered
21 reconstructive. It may be used to feminize the
22 silhouette in which case it may be considered
23 reconstructive, but the ultimate decision would
24 depend upon the particular of the case.

25 Q All right. And for a cisgender woman without

1 pathology, disease or a medical diagnosis, would
2 liposuction be cosmetic?

3 A So again, I would answer it the same way.
4 Liposuction and lipofilling may be used as an
5 adjunct in breast reconstruction for a cisgender
6 woman as well. It may be used to fill a defect in
7 someone's body, face, trunk, breasts that may be
8 considered reconstructive.

9 MR. CARLISLE: Okay. We've been going for
10 more than an hour. Is it okay if we take a short
11 break?

12 THE WITNESS: Please. Thank you.

13 (A brief recess was taken.)

14 Q All right, Dr. Schechter. How do you decide which
15 surgeries you perform for a patient?

16 A So that's part of the consultation. First I listen
17 -- meet with the patient, listen to them what their
18 goals and expectations are. I perform a history
19 and a physical examination, and then we discuss a
20 particular procedure. Oftentimes people have a
21 particular procedure in mind.

22 Q Is patient desire a driving factor in which surgery
23 is performed?

24 A Patient goals and expectations do influence which
25 procedure is performed?

1 Q If a patient asks for a surgery -- I'm sorry. If a
2 patient did not ask for a surgery, would you
3 perform that particular surgery?

4 A Generally the answer to that is no. However, it
5 would depend on their goals and expectations. So
6 by that, I mean if -- if a particular procedure,
7 which they may not have contemplated, would be
8 important in achieving one's goals or expectations,
9 we may discuss that procedure or they may recognize
10 that the goals and expectations may need to be
11 adjusted.

12 Q All right.

13 MR. CARLISLE: Kate, if you could put
14 Exhibit 18 on the screen, please.

15 (Ms. Meltzer complies with request.)

16 (Exhibit 18 marked.)

17 Q All right, Dr. Schechter. I'm showing you what
18 we'll mark as Exhibit 18. It's the Miller article.
19 I'm going to ask you just a few questions about
20 particular parts of this study. So first, this was
21 a retrospective study?

22 A I don't -- can you scroll down?

23 Q Yes. And if you look at the methods right there
24 (indicating).

25 A A retrospective review, yes.

1 Q All right. And in the Results paragraph, it looks
2 like 34 patients were included in the study?

3 A I believe so, but if you go to the -- let me -- I'd
4 like to see the Results section of the full
5 manuscript. This is just the abstract.

6 Q It's --

7 A Okay. Yep. Let's see.

8 Q -- page 68.

9 A Okay.

10 Q 34 patients.

11 A Can you just -- I just want to read the next -- the
12 conclusion. Okay. Thirty- -- 34 patients.

13 Q Okay. Is that what could be described as an
14 anecdotal study?

15 A I would say it's a case series.

16 Q And that's in distinction with a -- a systematic
17 study?

18 A I -- you're using the term systematic. I --

19 Q A meta-analysis, maybe?

20 A No, I wouldn't characterize studies like that.
21 When you hear the term systematic, I think more of
22 a systematic review where multiple papers looking
23 at a topic are grouped together. I look at this as
24 a case series in contrast to, for example,
25 randomized controlled studies, cross-sectional

1 studies, those sorts of things. Study design.

2 Q All right.

3 MR. CARLISLE: Can you go to page 69, Kate?

4 Are you on page 69? Yes.

5 Q And Dr. Schechter, if I could point your attention
6 to the first paragraph of the Discussion section.

7 A Uh-huh.

8 Q The authors write "Despite a large body of
9 literature dedicated to aesthetic breast
10 augmentation, there is a paucity of data dedicated
11 specifically to breast augmentation in transwomen.
12 Further, the majority of literature dates back to
13 the 1990s or earlier." Do you agree with that?

14 A Not necessarily. The term paucity, I'm -- I'm not
15 sure how they refer to that, whether it's quantity,
16 whether it's level of evidence. I can't say for --
17 for sure when the majority of studies were
18 conducted.

19 Q Do you have reason to dispute that finding?

20 A I can't say one way or the other.

21 Q All right.

22 MR. CARLISLE: Kate, if you could go to
23 page 72, please.

24 (Ms. Meltzer complies with request.)

25 Q Dr. Schechter, the paragraph stating "While our

1 results were relatively favorable," do you see
2 that?

3 A Yes.

4 Q The authors write "our group did experience
5 complications in 6 of the 34 patients,"
6 approximately 17.6 percent. Is that a significant
7 number of patients?

8 A The 34 or the 6 or both?

9 Q The 17.6 percent of patients, is that a significant
10 number to experience complications?

11 A That is a higher percentage than I experience in my
12 practice.

13 Q And overall in surgery, would you say that's a high
14 number?

15 A It would depend on the surgery and the patient
16 population.

17 Q What about for the particular surgery discussed
18 here or surgeries?

19 A The number quoted here is higher than I experience
20 in my practice.

21 Q Yeah. Sorry, I should be clear. Of -- and outside
22 of your practice across the country and for these
23 surgeries, is that a significant number,
24 17.6 percent, to experience complications?

25 A I think it depends on how complications are

1 defined, and I think the authors here are being
2 quite hard on themselves. For example, numbness,
3 hypersensitivity, when we look at the plastic
4 surgery literature in general as it relates to
5 implant placement, those are things that probably
6 most people wouldn't even consider a complication.
7 So I think that I would commend the authors here in
8 looking at minute things that probably most papers
9 wouldn't even consider a complication.

10 Q Do you consider those things complications?

11 A It would depend. I'm looking at asymmetry. So no
12 two sides of our body are symmetric. It would be
13 uncommon or unusual if everyone were perfectly
14 symmetric before surgery or after surgery. So I
15 would interpret this as the author is being
16 extremely attentive to conditions that others might
17 experience -- or might feel are not complications.

18 Hematoma, hematoma requiring removal, I would
19 say yes. Infection, yes. Poor scarring, I'd have
20 to see how they define the particular person they
21 answered. So I interpret this -- the authors in
22 this study to be -- I would commend them in looking
23 at the things that probably most people wouldn't
24 consider complications.

25 Q Right. And looking on the same page, the paragraph

1 starting "Based on our PROM's data," do you see
2 that, sir?

3 A Yeah. Can you scroll down -- or up, yeah. Okay.

4 Q All right. I'm going to point your attention to
5 that last sentence where it says "Further studies
6 are needed to determine validated, standardized
7 patient-reported outcome measures for
8 gender-affirming surgeries." Do you agree with
9 that statement?

10 A Well, the first thing that I was struck by the
11 "high level of satisfaction and improvement in our
12 patients' quality of life" and the hundred percent
13 of respondents completely agreeing or agree that
14 gender dysphoria improved. The need for further
15 studies is -- is a call that we would make in
16 virtually every area of medicine and surgery, so I
17 would say it's consistent with the general fields
18 of medicine and surgery.

19 Q Do you agree there's a lack of validated,
20 standardized, patient-reported outcome measures for
21 gender affirming surgery?

22 A No.

23 Q Why not?

24 A Because those measures, probably since this paper
25 was written, either have been or are being

1 developed and -- and so while, as I said, we could
2 always use more data and more information, I don't
3 believe that there's insufficient information at
4 this time.

5 Q I think you said those measures may be in
6 development. Was that an accurate statement?

7 A There are measures -- more measures in development,
8 yes.

9 Q And have you cited a paper since the date of this
10 one wherein those were utilized or discussed?

11 A I'd have to look at my report. I don't recall. I
12 do recall some papers use outcome measures, but I
13 -- I don't recall each and every paper.

14 MR. CARLISLE: Okay. Let's go to Exhibit 19,
15 please. Hey, Kate. Can you put up Exhibit 19?

16 MR. MELTZER: Yeah. Sorry. I have it -- let
17 me reshare it really quick.

18 MR. CARLISLE: Okay. Thank you.

19 (Exhibit 19 marked.)

20 Q Doctor, I'm showing you what we'll mark as
21 Exhibit 19, and you cite this article in Footnote 6
22 of your report. Looking at the bottom of page 2,
23 top of page 3, in the Results section, the authors
24 write "Thirty-six patients completed surveys 6
25 weeks after surgery, and 22 patients completed

1 surveys 1 year after surgery, for response rates of
2 71 percent and 43 percent, respectively." Doctor,
3 do you think 43 percent is a low response rate?

4 A Well, it looks like you've got only the abstract of
5 the article here. If you have the full article, I
6 can review it.

7 Q All right. Well, we will come back to that then.

8 Generally in a study like this that requires
9 participants to respond to a survey, let's say, is
10 43 percent a low response rate?

11 A 43 percent may -- is likely consistent with many
12 survey studies.

13 Q Is 43 percent a low response rate?

14 A Likely consistent with -- with many survey studies.

15 Q Based on the abstract of this article, it appears
16 that it studied responses only out to a year. Do
17 you agree with that?

18 A It says it completed surveys one year after
19 surgery, but I -- I can't extrapolate to the full
20 article without seeing the full article.

21 Q Based on the abstract, you would agree, though, the
22 study says nothing about quality of life or
23 outcomes long term?

24 A I think that it's insufficient for me to look only
25 at the abstract and then opine on the full article.

1 Q Okay.

2 MR. CARLISLE: Let's put up Exhibit 20,
3 please.

4 (Ms. Meltzer complies with request.)

5 (A discussion was held off the record.)

6 (Exhibit 20 marked.)

7 Q Okay. Sir, I'm showing you what's been marked as
8 Exhibit 20. The article is "female-to-male
9 transgender quality of life," Emily Newfield. This
10 -- are you familiar with this study, sir?

11 A I'm sorry. Who did you -- who did you say was the
12 author?

13 MR. CARLISLE: Kate, if you could go down to
14 the next page?

15 (Ms. Meltzer complies with request.)

16 A Oh, okay. I -- I may have seen this study. I
17 don't recall.

18 Q Okay. You cite it in Footnote 7 of your report,
19 correct?

20 A Okay. If you have my report and it's in there,
21 then -- then I would say yes.

22 Q Okay.

23 MR. CARLISLE: Let's go to page 1454.

24 (Ms. Meltzer complies with request.)

25 Q Doctor, do you see the section called "Study

1 limitations"?

2 A Yes.

3 Q And do you see in that first sentence there the
4 author has mentioned the study is biased by
5 self-selection?

6 A Yes.

7 Q Do you agree that that's a limitation of a study
8 like this?

9 A I'd have to review the full study, but to the
10 extent that not all transgender people want surgery
11 or need surgery and to the extent that -- that the
12 study -- can you go -- let me read -- go back up to
13 the top and let me look at the -- at least begin
14 with the abstract.

15 Q Sure.

16 (Ms. Meltzer complies with request.)

17 A Okay. Okay. And can you go down, please? Let me
18 just refresh my memory on this, if you -- okay.
19 And if you can just scroll down again. Thanks.
20 Yeah, thanks. And if you can scroll down, please.
21 And if you'd just scroll down a little bit, please.
22 Sorry, back. I'm just reading the method. Thanks.
23 Okay. And you can scroll so I can see the top of
24 the page, please. Okay. And if you can scroll
25 down. Yep. Go ahead and keep -- keep going.

1 Thanks. Okay. Okay. If you can scroll down to
2 the next page. Okay. If you can scroll down.
3 Okay.

4 So I guess bias relates to the fact that, for
5 example, the surgical treatment is focused -- or
6 surgical treatment analysis on people who have
7 undergone top surgery. So the bias is in the
8 extent that these are people who have undergone
9 intervention which they found helpful.

10 MR. CARLISLE: Kate, if you could go to
11 page 1455, please.

12 (Ms. Meltzer complies with request.)

13 Q All right. Sir, do you see the first paragraph
14 there, the sentence that says "This limitation may
15 be the source of our racially-biased sample; more
16 individuals report living in Canada than identify
17 as" --

18 A No. I'm sorry. Show me -- where are we?

19 Q I'm sorry. The first full paragraph.

20 A Okay.

21 Q Sentence starts "This limitation may be the source
22 of our racially-biased sample."

23 A I am not seeing --

24 MS. MELTZER: (Indicating.)

25 A Oh, okay. First full sentence, okay. Okay.

1 Q All right. And then the second full paragraph, the
2 authors write, The issues of potential bias are
3 significant and, as such, the reported -- the
4 results reported here may not reflect the health
5 and well-being of the entire FtM transgender
6 community, but only the experiences of white,
7 educated, urban FtMs. Do you see that?

8 A I see that.

9 MR. CARLISLE: Okay. And Kate, if you could
10 go to the previous page, please, 1454.

11 (Ms. Meltzer complies with request.)

12 Q Dr. Schechter, under the Study limitations
13 section --

14 A Uh-huh.

15 Q -- the second sentence there states --

16 A Yes.

17 Q -- "To be transgender is to identify as such -
18 there is no particular physical finding or
19 diagnostic test that can certify that an individual
20 is truly the gender he or she reports to be." Do
21 you agree with that?

22 A I agree that there's not a particular laboratory
23 test or physical finding, but that doesn't diminish
24 the validity of the diagnosis as a medical
25 condition.

1 Q Let me ask you this, sir: As a surgeon, do you
2 have to rely on your patients self-reports about
3 his or her gender identity?

4 A Well, no. I work in context with mental health
5 professionals and primary care professionals. So
6 while I don't make that diagnosis, I do have to
7 review those assessments as well as meet with and
8 interview the patient and examine the patient.

9 Q Have you ever doubted or challenged one of your
10 patient's statements regarding his or her gender
11 identity?

12 A I've declined to perform surgery on people where I
13 was unclear of the diagnosis or not certain of the
14 diagnosis.

15 Q Okay. What made you uncertain about the diagnosis?

16 A One person I can think of who expressed being
17 intersex and not feeling a need to have a mental
18 health assessment prior to surgery.

19 Q Any other patients like -- in that same situation?

20 A Individuals with unrealistic goals or expectations.

21 MR. CARLISLE: All right. Let's go to
22 Exhibit 21, please.

23 (Ms. Meltzer complies with request.)

24 (Exhibit 21 marked.)

25 Q All right, sir. I'm showing you what's been marked

1 as Exhibit 21. It's the article you cited in
2 Footnote 8, Weigert. Do you see the article, sir?

3 A I do.

4 Q Okay. I'm going to draw your attention to
5 page 1428, please, Kate.

6 (Ms. Meltzer complies with request.)

7 Q Okay. If you can go down a little bit to the
8 paragraph that starts "Despite meaningful results."
9 Do you see that, sir?

10 A Yes.

11 Q The authors write "Despite meaningful results on
12 quality of life, this study has some significant
13 limitations. A significant number of
14 questionnaires were missing in the long term (14 of
15 35 patients). Eight patients were interviewed too
16 early, as less than 6 months had elapsed since the
17 intervention, and six patients were lost to
18 follow-up." Do you agree that those are
19 limitations of a study like this?

20 A Again, as with any questionnaire, it's not uncommon
21 to have people who are lost to follow-up or don't
22 complete the questionnaire, and so -- yeah.

23 Q Would the ideal questionnaire have a higher
24 response rate and no participants lost to
25 follow-up?

1 A Well, again, this is one particular sentence in one
2 study, and I don't take any particular study and
3 certainly one sentence from any particular study as
4 being dispositive. We look at consistency, one of
5 the things we looked at, and I think one of the
6 mischaracterizations we have is that the levels of
7 evidence in the gender-affirming literature are
8 quite similar to that of the plastic surgery
9 literature as a whole, and yet criticisms are
10 disproportionate in this area compared to other
11 areas of plastic surgery. So, for example, survey
12 of response rate or being lost to follow-up are
13 situations with which we have to deal with in all
14 areas of -- of medicine and surgery.

15 Q So as long as the studies are inconsistently poor,
16 you can rely on them?

17 A I don't rely on any single study to make my
18 decision. My decisions are based on not only the
19 medical literature, which is one part of medical
20 decision making, but also my experience in caring
21 for thousands -- thousands of people. And yet in
22 spite of study limitations, what the study doesn't
23 say is that performing surgery was not -- if you
24 can go to the -- go up to the conclusion for me --
25 go up to the first page.

1 (Ms. Meltzer complies with request.)

2 A Okay. So the conclusion, as you see, is that --
3 gains in breast satisfaction, psychosocial
4 well-being, and sexual well-being in male-to-female
5 transsexual patients undergoing breast augmentation
6 are statistically significant and clinically
7 meaningful to the patient at four months after
8 surgery and in the long term. And so rather than
9 extracting one particular sentence, we look at the
10 overall study. We look at this study and the
11 context of the literature as a whole. We look at
12 the literature in the whole as in the context of my
13 clinical experience and the individual patient. So
14 the study certainly, as we would expect for any
15 scientific study to discuss limitations, doesn't
16 conclude -- or concludes that surgery is clinically
17 meaningful in a statistically significant way.

18 Q You would agree a study's limitations should be
19 taken into account?

20 A I would agree that limitations are routinely
21 discussed in all -- in all areas of medicine and
22 surgery, and that's part of the process in not only
23 reading the study but then discussing these
24 studies, meeting with patients, understanding the
25 impact. And so this -- that's true of whether

1 surgery is gender-affirming surgery or plastic
2 surgery in other areas.

3 MR. CARLISLE: All right. Let's go to
4 Exhibit 22.

5 (Ms. Meltzer complies with request.)

6 (Exhibit 22 marked.)

7 Q All right, sir. I'm showing you what's been marked
8 as Exhibit 22. This is the Horbach article you
9 cited in Footnote 9 of your report. So if you look
10 at -- let's start with the abstract. If you look
11 at the Aim, paragraph do you see that?

12 A Yes.

13 Q So this looks like it was a systematic review of
14 studies regarding outcomes of available techniques
15 for a vaginoplasty, right?

16 A Outcomes of techniques, yes.

17 Q Okay. And if you jump down to the results
18 paragraph of the abstract, you see the authors note
19 "Twenty-six studies satisfied the inclusion
20 criteria. The majority of these studies were
21 retrospective case series of low to intermediate
22 quality." Do you see that?

23 A I see that.

24 Q Do you agree with that?

25 A Well, I have to look at the study, but they likely

1 refer to the levels of evidence. And again, the
2 levels of evidence in gender-affirming surgery are
3 quite consistent with that in other areas of
4 plastic surgery.

5 Q So the studies on this topic tend to be low to
6 intermediate quality?

7 A Most studies are -- I prefer to use level of
8 evidence, and most are Level 3, 4 and 5. And
9 that's for the reasons discussed in my report and
10 consistent with other areas of surgery which
11 include -- there's no blinding or placebo in
12 surgery, and, of course, we don't randomize people
13 or deny people medically necessary care to
14 randomize them. And so I think if we discuss level
15 of evidence, 3, 4, 5, that's consistent with other
16 areas of plastic surgery.

17 Q Okay.

18 MR. CARLISLE: Kate, if you could go to
19 page 1510.

20 (Ms. Meltzer complies with request.)

21 Q All right, sir. In the Conclusion and
22 Recommendations section, do you see the first
23 paragraph there the authors write "It is impossible
24 to identify the 'best available' technique for
25 vaginoplasty in MtF patients due to a lack of

1 high-quality evidence and the heterogeneity of
2 surgical techniques, patient groups, and outcome
3 measures. Do you agree with that conclusion?

4 A I think it's a conclusion that I could draw in many
5 areas of plastic surgery because we do
6 individualized care. And, of course, heterogeneity
7 in surgical techniques is quite common in plastic
8 surgery. So I don't agree that this is unique to
9 gender-affirming surgery.

10 MR. CARLISLE: All right. Let's go to the
11 next page, please, 1511.

12 (Ms. Meltzer complies with request.)

13 Q In that first full paragraph, sir, you see the
14 authors quote "There is a need for prospective
15 studies with standardized surgical procedures,
16 larger patient groups, and a longer follow-up
17 period. Uniformity in outcome measurement tools
18 such as validated questionnaires and scores for
19 sexual function and QoL is mandatory for
20 comparability between studies and correct
21 interpretation of obtained data." Do you agree
22 with that?

23 A I think, as we said, this study is looking at
24 techniques, not at efficacy. And so as a general
25 rule, if we're looking to compare two different

1 techniques, you know, then we would want to compare
2 standardized techniques. But this study is not
3 speaking or that conclusion is not in reference to
4 the efficacy of gender-affirming surgery, and in
5 all areas of plastic surgery, or at least most
6 areas of plastic surgery, there are options as --
7 as to what treatment a patient would undergo, and
8 inherent in those options is patient choice.

9 Q All right. Moving right along, let's go to
10 Exhibit 23.

11 (Ms. Meltzer complies with request.)

12 (Exhibit 23 marked.)

13 Q Dr. Schechter, I'm showing you Exhibit 23 on your
14 screen, which is the Hess article. You cite this
15 in Footnote 10 of your report.

16 A Yes. I -- I don't know that it's 10, but I know
17 the article.

18 Q Okay. Good. Let's start at the Summary at the
19 top. The methods -- it looks like this was a study
20 that relied on self-reporting questionnaires from
21 MtF surgical patients.

22 A Okay.

23 Q All right. And then in the next paragraph of the
24 Summary, the results, it says 119 (46.9% of the
25 patients filled out and returned the

1 questionnaires. So again, it sounds like this
2 study also was limited by the patient response
3 rate, right?

4 A No. I think compared to survey studies in other
5 areas of plastic surgery, almost 50 percent at five
6 years is pretty good.

7 Q Well, if you go to Conclusion paragraph right there
8 in the Summary, the authors write in the second
9 sentence "These findings must be interpreted with
10 caution, however, because fewer than half of the
11 questionnaires were returned." Do you agree with
12 that?

13 A I agree that lack of filling out questionnaires is
14 a common problem in plastic surgery and, as we've
15 discussed, is not an issue unique to
16 gender-affirming surgery but one which impacts all
17 areas of plastic surgery.

18 Q All right.

19 MR. CARLISLE: Kate, if you could go to
20 page 800, please.

21 (Ms. Meltzer complies with request.)

22 Q All right, Dr. Schechter. In the Limitations
23 section there, the authors write "The response rate
24 of less than 50% must be mentioned as a shortcoming
25 of this study. This may have led to a bias in the

1 results. If all patients who did not take part in
2 the survey were dissatisfied, up to 50.1% and 54.6%
3 would be dissatisfied with aesthetic or functional
4 outcome respectively." Would you agree that a
5 response rate of less than 50 percent could suggest
6 a bias in the results of this study?

7 A So first I would say that a response rate of almost
8 50 percent at five years is pretty good and is not
9 inconsistent with the plastic surgery literature in
10 general. The study found rather compelling results
11 as to the efficacy of gender-affirming surgery. As
12 with all areas of medicine and surgery, we discuss
13 limitations of the study as the authors are doing
14 here. This is a limitation that would be
15 consistent with probably most survey studies in
16 plastic surgery.

17 Q Okay. Thank you.

18 MR. CARLISLE: Kate, let's go to Exhibit 24.

19 (Ms. Meltzer complies with request.)

20 (Exhibit 24 marked.)

21 Q All right, Dr. Schechter. I'm showing you what's
22 been marked as Exhibit 24. You cite this article
23 on Footnote 11 of your report. Forgive me, I'm
24 going to mess up this name, but I believe it's
25 Miriam Hadj-Moussa?

1 A Yes.

2 Q And the article is called "Feminizing Genital
3 Gender-Confirmation Surgery."

4 MR. CARLISLE: Let's go to page 6, please.

5 (Ms. Meltzer complies with request.)

6 Q And I want to focus on some of the complications of
7 vaginoplasty these authors found. Do you see the
8 section at the bottom starting "Vaginoplasty
9 Complications"?

10 A Uh --

11 MR. CARLISLE: Kate, can you go down a little
12 bit?

13 (Ms. Meltzer complies with request.)

14 A Okay.

15 Q All right. The authors write starting in the
16 second sentence "Vaginoplasty requires disassembly,
17 rearrangement, and reconstruction of multiple organ
18 systems and thus is inherently associated with a
19 diverse complication profile." Do you agree with
20 that, sir?

21 A I wouldn't qualify them as multiple organ systems.
22 I don't agree with that. I do agree with the first
23 sentence, "All major surgeries carry a risk of
24 complications and feminizing GCS is not exception."

25 Q All right.

1 MR. CARLISLE: And if we could go to page 8.

2 (Witness complies with request.)

3 Q Sir, at the top paragraph there, do you see the
4 authors write "Patients also should be aware that
5 25% to 80% of patients undergo secondary procedures
6 to optimize voiding or for vulvar cosmesis after
7 vaginoplasty." Do you see that sentence?

8 A I see that sentence.

9 Q All right. Help me out. What does voiding mean?

10 A I'm -- can you go up -- can you go to 7? Let me
11 see.

12 (Ms. Meltzer complies with request.)

13 A It can generally mean either urinary or -- either
14 urinary function or bowel function, so I'm not sure
15 how they're including that. Presumably it's
16 urinary function here.

17 Q Okay. And what about vulvar cosmesis?

18 A Aesthetic result.

19 Q All right.

20 MR. CARLISLE: Kate, if you could go back to
21 page 8.

22 (Ms. Meltzer complies with request.)

23 Q Do you agree with that statement, Dr. Schechter?

24 A Again, I would say that's higher than in my patient
25 practice. I agree in general. As I said with the

1 first sentence that complications can occur with
2 all surgery, and I would add that the complication
3 rate in gender-affirming vaginoplasty is consistent
4 and commensurate with that for vaginoplasty or
5 vaginal reconstruction performed for other
6 conditions.

7 Q As part of the informed consent process, do you
8 inform your surgical patients about the risk of
9 secondary procedures?

10 A We -- we discuss secondary procedures. I -- I
11 don't know that I call that a risk.

12 Q About the possibility then?

13 A Yes.

14 Q Okay. And if you could go down to the next
15 section, Intraoperative Complications, the authors
16 write in the second sentence "Rectal injuries
17 sustained during dissection of the neovaginal space
18 are the most frequently reported (0.45-4.5%)."
19 Does that sound accurate to you?

20 A I think it's accurate with the quoted -- I think
21 that's accurate with the quoted literature.

22 Q And then two sentences later, "Most patients who
23 sustain a rectal injury do not develop any
24 long-term sequelae, although they are at a greater
25 risk of developing a rectovaginal fistula." Do you

1 agree that they're at greater risk of developing a
2 fistula?

3 A So I would -- so I agree that most patients don't
4 have long-term sequelae. I do agree that an
5 intraoperative rectal injury would predispose to a
6 rectovaginal fistula as it would with genitourinary
7 reconstruction for -- for other conditions.

8 Q All right. And then the next sentence there, the
9 authors write "Urethral injuries occur in 0% to
10 4.0% of cases and can be repaired primarily with
11 absorbable suture and prolonged catheter drainage."
12 Is that range consistent with your experience?

13 A I would say the 4 percent is higher than my
14 experience, but I -- I think that's a reasonable
15 estimate.

16 Q All right. The next section discusses
17 postoperative complications, and in the Genital
18 Complications section, the authors write "A modest
19 percentage of patients are affected by stenosis of
20 their introitus (mean = 12%, range = 1.2-15%)." Do
21 you agree with that?

22 A I think that that's probably a reasonable number
23 and -- and also probably lower than when perfor- --
24 when vaginal reconstruction is performed for other
25 conditions.

1 Q And what does stenosis refer to here?

2 A Likely referring to tightness.

3 Q Okay. If you go to the next paragraph,
4 rectovaginal fistulas, the authors write "They
5 complicate only approximately 1% of cases but
6 represent a distressing outcome for patients and
7 their surgeons. In the largest published series of
8 neovaginal fistulas in transgender women after GCS,
9 van der Sluis et al investigated the
10 characteristics of 13 rectovaginal fistulas in a
11 cohort of 1,082 patients. Every patient presented
12 with foul-smelling discharge or passage of flatus
13 and/or feces from her neovagina, often immediately
14 after removing the neovaginal stent placed during
15 surgery." Is that an accurate description of a
16 fistula?

17 A So I'm looking at -- he's got 13 fistulas of almost
18 1,100 patients. So let's see. That would be about
19 1 -- roughly 1 percent, a little bit more than
20 1 percent. No. Excuse me. .1 percent. And so
21 .1 percent, probably a reasonable -- I think
22 reasonable number to quote, and I think that that's
23 an accurate description of a rectovaginal fistula,
24 whether a person is transgender or cisgender,
25 having had, for example, a rectovaginal fistula

1 either iatrogenic or -- or for other reasons.

2 Q And during the informed consent process, do you
3 describe fistulas to your patients along similar
4 lines?

5 A I do describe fistula to my patients, yes.

6 Q Okay. Sir, at the top of the same page on the next
7 column, the authors write "Extensive necrosis of
8 the neovagina, labia, or neoclitoris can occur but
9 is infrequent --

10 A Can you go -- I'm sorry, I just can't see it.

11 Q Oh, I'm sorry.

12 A Okay.

13 (Ms. Meltzer indicates.)

14 Q Right there.

15 A Yeah.

16 Q Extensive necrosis of the neovagina, labia, or
17 neoclitoris can occur but is infrequent because
18 most pelvic structures are generously vascularized.
19 Is that accurate in your experience?

20 A I would say extensive necrosis is not common.

21 Q Do you inform your patients about that possibility?

22 A Yes.

23 Q Okay. And then the next section, Urinary
24 Complications, the authors write, A misdirected
25 urinary stream is the most common urinary side

1 effect of vaginoplasty, affecting 5.6 to 33% of
2 patients. Do you agree with that?

3 A I would say that many patients experience spraying
4 of their urine after surgery, which is generally
5 self-limited and tends to resolve over time as
6 swelling and sutures resolve, and, if not, may be
7 treated usually with an outpatient procedure. But
8 I can't think of having to do that, if I've done it
9 once in the last maybe two to -- two years.

10 Q All right.

11 A That's typi- -- yep.

12 Q And then at the -- the last paragraph of this
13 page --

14 MR. CARLISLE: Can you go down a little bit?

15 (Witness complies with request.)

16 Q The authors write, Clinically significant bleeding
17 occurs in 1.7 to 10% of cases and commonly arises
18 from the corpus spongiosum. Is that accurate?

19 A I think that's accurate, yes, and is, again,
20 consistent with operating on that tissue for
21 whatever the condition or etiology is.

22 Q Okay. On the bottom of page 9 there's a section on
23 Areas of Lower Patient Satisfaction.

24 A Okay.

25 Q And lubrication is one area of lower patient

1 satisfaction; is that correct?

2 A I would say that's an issue for cisgender women and
3 for transgender women. Especially as cisgender
4 women age, vaginal dryness is not uncommon.

5 Q Do you agree that most vaginoplasty patients will
6 require additional lubrication for sexual
7 intercourse?

8 A I agree that most patients who've undergone vaginal
9 reconstruction will require lubrication for
10 intercourse.

11 MR. CARLISLE: And if you'd go to the next
12 page, please.

13 (Ms. Meltzer complies with request.)

14 Q The authors write about dyspareunia. Rates of
15 dyspareunia were widely -- excuse me -- vary widely
16 in the literature, from 0% to 24.7 percent. Is
17 that accurate in your experience?

18 A I would say that is accurate, again, for women
19 undergoing -- whether a cisgender or transgender,
20 undergoing vaginal reconstruction, I think that's
21 an accurate statement.

22 Q Okay. Let's move on to Exhibit 26.

23 MR. CARLISLE: Let me know if you want a
24 break.

25 THE WITNESS: Can you give me two seconds to

1 call the operating room?

2 MR. CARLISLE: Yeah. Yep.

3 THE WITNESS: Let me just do that real quick.

4 (A brief recess was taken.)

5 THE WITNESS: Okay. Not answering, so we'll
6 keep going.

7 MR. CARLISLE: Okay.

8 (Exhibit 26 marked.)

9 Q Okay. I'm showing you what's been marked as
10 Exhibit 26, sir. This is a study from Frederick,
11 "Chest Surgery in Female to Male Transgender
12 Individuals," that you cite in Footnote 13?

13 A Okay.

14 Q If we go to page 251, Table 2. Do you see in
15 Table 2 the authors discuss the frequency of
16 complications and resulting satisfaction scores?

17 A Yes.

18 Q And it looks like their finding is that there are
19 long-term complications in 10.2 percent of the
20 patients for auxiliary dog ear, and then for
21 hypertrophic scar long-term complications in 13.6
22 of the patients. Is that accurate in your
23 experience?

24 A I think that's high from my -- from -- in my
25 practice. But I think if you also go back to the

1 conclusion, if you go back to the abstract page,
2 the authors cite, if we can go to that first page,
3 that -- if you look at conclusions, "Female to male
4 transgender mastectomy can be performed with low
5 complication rate and high satisfaction." So I
6 think those -- again, what the authors refer to as
7 complication may be subjective to some degree, but
8 I would say higher than we experience in -- in our
9 practice.

10 Q Okay. And going to the last page, page 253, in
11 that first full paragraph, the authors write "There
12 is no validated method of assessing transgender
13 surgery outcomes, because this population presents
14 problems for follow-up." Do you agree with that?

15 A No, not necessarily. I do think the fact that many
16 people do travel for surgery can present challenges
17 as it would for practices where people travel. I
18 think electronic communications have improved and
19 the ability to have video visits and other adjuncts
20 have helped with that since this paper has been
21 published.

22 Q This paper was published in 2017, right?

23 A Yeah. And so, you know, I suppose, you know, one
24 of the things that came out of COVID was really the
25 expansion of the telehealth, and I think telehealth

1 has been very helpful in this area because people
2 often do travel. And so it does allow us to
3 maintain contact with people.

4 Q Right. In the next sentence the authors explain
5 "These surgeries are relatively uncommon, the
6 patients often travel long distances for their
7 operation, patients often move and change identity,
8 and transgender patients are particularly concerned
9 with maintaining confidentiality." Are all those
10 reasons why this population presents for follow-up?

11 A I'm sorry. Why this presents --

12 Q Why this population presents problems for
13 follow-up.

14 A Well, I think he's referencing two articles. It
15 looks like an article, a footnote from Spack, which
16 looks like an article from '13, 2013, and then an
17 article from 2012. The term uncommon, I suppose,
18 depends upon one's practice. These are quite
19 common procedures in my practice. I would agree
20 it's not uncommon for people to travel long
21 distance, but since the publication of this, one of
22 the things that we have seen expand is telehealth.
23 And also the standards of care, version 8, one of
24 the important components of that, is -- is the
25 aftercare plan and providing for that plan as part

1 of the preoperative process. So helping to --
2 helping to improve follow-up following surgery.

3 Q All right. Thank you, sir.

4 MR. CARLISLE: Let's go to Exhibit 29. We're
5 going to skip a couple, Kate.

6 (Exhibit 29 marked.)

7 (Ms. Meltzer complies with request.)

8 Q Dr. Schechter, I'm showing you what's been marked
9 as Exhibit 29. This is cited in Footnote 16. It
10 is the Department of Health and Human Services
11 Department -- Departmental Appeals Board Appellate
12 Division Decision. Do you see that?

13 A I do.

14 Q You're familiar with this decision?

15 A Yes.

16 Q And it was, as the first paragraph explains, a
17 challenge to a National Coverage Determination
18 disallowing costs for transsexual surgery.

19 A I'm just trying to see where you're -- I'm sorry.
20 Where were you -- you're looking --

21 Q Yeah, the -- the first sentence "The Board has
22 determined that the National Coverage Determination
23 denying Medicare coverage of all transsexual
24 surgery as a treatment for transsexualism is not
25 valid under the 'reasonableness standard.'"

1 A Yes. So this applies to the Medicare population
2 only. And I think, as we know, that decision, you
3 know, in May of 2014 was revers- -- or the decision
4 for Medicare to cover gender-affirming surgery was
5 allow- -- was -- I should say the exclusion was
6 removed in 2014. And so the National Coverage
7 Determination relates to the Medicare population
8 only. And so when you have a patient population
9 that's been denied access to medically-necessary
10 care, it's not surprising that there weren't
11 studies looking at the impact of surgery on people
12 of -- of Medicare age, typically 65 or older, and
13 additionally most conditions we operate on don't
14 have a National Coverage Determination. So it's,
15 again, not uncommon, in fact, probably more common
16 than not, that most conditions we operate on don't
17 have an NCD. But now having said that, at least
18 since 2014, to the best of my knowledge, we have
19 not had challenges or difficulty receiving coverage
20 for Medicare beneficiaries for gender-affirming
21 surgery.

22 Q All right. And you cite this article on
23 paragraph 50 of your report to support your
24 conclusion that surgery is safe, effective, and
25 medically necessary.

1 A Yes.

2 Q I want to -- I want to point you to the last
3 sentence of this first paragraph here where it says
4 "The Centers for Medicare and Medicaid Services,
5 which is responsible for issuing and revising NCDs,
6 did not defend the NCD or the NCD record in this
7 proceeding and did not challenge any of the new
8 evidence submitted to the board." So is it your
9 understanding that in overturning the NCD, CMS
10 didn't even challenge it, didn't even challenge the
11 evidence or any of the witnesses?

12 A Well, I think, as I recall the decision was -- from
13 CMS or HHS was that the denial was based on
14 outdated science or at least one of -- one of the
15 bases of --

16 Q Okay. Let's go to Exhibit 30.

17 (Exhibit 30 marked.)

18 Q All right. Dr. Schechter, I'm showing you what's
19 been marked as Exhibit 30. This is a July 2023
20 article by Mark Bishop called "Pain and Dysfunction
21 Reported After Gender-Affirming Surgery: A Scoping
22 Review." This was not cited in your report, so my
23 question is are you familiar with this study?

24 A I think I've seen it.

25 Q Okay. Let's just look at the first page here then.

1 The Objective paragraph --

2 A Uh-huh.

3 Q -- it looks like the purpose of this study was to
4 look at types and rates of pain in -- related to
5 gender-affirming surgeries. Do you agree?

6 A The goal -- so scoping review, meaning not a
7 systematic review, so those are different. To
8 determine the types and rates of pain or
9 dysfunction outcomes reported. Okay.

10 Q All right. And then the author concluded on that
11 first page, if you look at this Conclusion
12 paragraph, "Many published studies do not
13 systematically collect specific or standardized
14 information about pain and dysfunction after
15 gender-affirming surgery." Do you agree with that?

16 A So I'm looking at this, and it's written by a
17 physical therapist, and so I would say this is
18 something -- or the incorporation of physical
19 therapy is something we did probably five years
20 ago. So a scoping review that these authors do is
21 not a systematic review. It's -- it's different.
22 It's more limited.

23 I would generally say that the incorporation
24 of pelvic floor physical therapy, as we've done and
25 many large centers have done before surgery, has

1 been very beneficial for patients, including
2 benefits in the postoperative period. So I'm not
3 sure the familiarity of this group or their
4 experience in caring for patients. I agree in
5 general that the incorporation of pelvic floor
6 physical therapists has been -- has been quite --
7 quite helpful in our practice, and I think as -- as
8 we may have discussed, as part of the pelvic -- as
9 part of the preoperative meeting, includes meeting
10 with our pelvic floor physical therapy and part of
11 the postoperative care following vaginoplasty is
12 working routinely with the pelvic floor physical
13 therapist.

14 Q Sir, do you agree that many published studies do
15 not systematically collect specific or standardized
16 information about pain or dysfunction after
17 gender-affirming surgery?

18 A I don't know what -- to what they're referring by
19 the term systematic. Many report on pain and, as
20 you just went through in the last article, urinary
21 dysfunction and quoted a variety of rates, so I --
22 I don't agree with that.

23 Q Okay.

24 MR. CARLISLE: If you could go to page 4,
25 please, Kate.

1 (Ms. Meltzer complies with request.)

2 Q Down at this bottom paragraph these authors cite
3 vaginal stenosis as the most frequently mentioned
4 complication. Is that true in your experience?

5 A Can you show me where you're looking there?

6 Q Yes, sir. Bottom paragraph --

7 A Okay.

8 Q Under Feminizing vaginoplasty.

9 A No, I don't think that's the most common. I -- I
10 think probably minor self-limited wound disruptions
11 are the most common complication generally treated
12 as an outpatient with local -- local care.

13 Q Okay. If you go to the next column, the authors
14 discuss incontinence symptoms. And the second
15 sentence there says "The only meta-analysis
16 calculated the rate of all incontinence symptoms to
17 be 16.9%." Do you agree with that?

18 A I'd have to look at the meta-analysis. You know,
19 this is part of their discuss- -- this is part of
20 the discussion or their interpretation of -- of
21 another study. So I'd have to look at that study
22 to comment on it.

23 Q All right. Fair enough. In the next paragraph,
24 the authors write "Pain was reported in the lower
25 back, hip, pelvis, genitals (not sex related), and

1 abdomen across multiple reviews and empirical
2 studies of vaginoplasty. Of these studies
3 reporting pain, up to 40% of patients reported
4 pelvic pain unrelated to intercourse." Is this
5 type of pain they're describing, do you see that in
6 your experience?

7 A Can you just go -- can I see what the title is,
8 too? Can you just go back to the article -- or the
9 title of the article?

10 Q Oh, the first page?

11 A Yeah. Okay. So I don't know -- I'd have to look
12 and see if they're referring -- because they've
13 referenced chest surgery and breast augmentation,
14 and so, for example, things that they describe, the
15 back pain is not necessarily something that we see
16 commonly, for example, after a vaginoplasty. And
17 again, they're kind of collating a number -- a
18 number of different studies. I do think the
19 incorporation, as we said earlier, of pelvic floor
20 physical therapists has been important and very
21 helpful. So to the extent that the authors
22 recommend incorporating pelvic floor physical
23 therapy into a gender-affirming surgical practice,
24 that I would agree.

25 Q Because it's necessary post-surgery for your

1 patients?

2 A I think it's quite helpful. I think it's one of
3 the things that we did with the Illinois Department
4 of Corrections, and that was part of our emphasis
5 and focus was on aftercare and ensuring, to the
6 best we could, the -- that people would be able to
7 dilate in a safe space, be comfortable dilating,
8 they'd have appropriate access, for example, to
9 their dilators. And so I would say it was really
10 a -- a team approach, you know, with our team and
11 the Illinois Department of Corrections to -- to
12 help, to the best extent we could, ensure that
13 people were optimized both before and after
14 surgery.

15 Q All right. Lastly, this last paragraph here,
16 dyspareunia, again, is discussed. And they write
17 "Dyspareunia was reported in multiple review
18 articles with 1 systematic review reporting a
19 median rate of 19% but ranging from 0 to as high as
20 75% depending on the assessment method." Is that
21 accurate from your experience?

22 A I would say 75 percent is high, but I would say
23 20 percent is probably reasonable and consistent
24 with women, whether cisgender or transgender,
25 who've undergone vaginal reconstruction for other

1 conditions.

2 Q All right.

3 MR. CARLISLE: Kate, you can stop sharing your
4 screen.

5 Q We've made it through all the articles,
6 Dr. Schechter. Thanks for your stamina there.

7 MR. CARLISLE: Maybe let's take another short
8 break. Is that okay?

9 THE WITNESS: That would be great.

10 (A brief recess was taken.)

11 Q All right. Dr. Schechter, of all the studies we've
12 discussed, how many of their participants were
13 convicted felons?

14 A I can't say that of the studies we discussed anyone
15 mentioned their criminal record.

16 Q And so it follows that you don't know of any study
17 participants who were serving long prison
18 sentences?

19 A I can't speak to what their history was and whether
20 there was previous incarceration.

21 Q Of all the participants in the studies we've
22 discussed today, do you have any idea how many had
23 underlying mental health comorbidities?

24 A I'd have to go back. I don't recall specifically
25 the studies that we have discussed but --

1 regarding, you said, mental health comorbidities?

2 Q Yes.

3 A Yeah. I'd have -- I don't recall offhand.

4 Q Earlier in our deposition you described
5 gender-confirmation surgeries as reconstructive.

6 Do you recall that?

7 A Yes, generally.

8 Q Okay. I want to get a clearer answer on this.

9 What, exactly, are the surgeries reconstructive of?

10 A They are allowing a person's body to be congruous
11 with their identity. We also consider many
12 surgeries in plastic surgery to be constructive.
13 And so just as, for example, someone born with a
14 congenital difference, we're reconstructing the
15 appropriate physical morphology, we're doing a
16 similar function for -- in gender-affirming or
17 gender-confirming surgery.

18 Q Doctor, how is WPATH relevant to your practice?

19 A So I serve as the treasurer and on the executive
20 committee of WPATH. I was the co-lead author for
21 the Surgery and Aftercare chapter of the Standards
22 of Care, Version 8.

23 Q Do you refer to WPATH in your daily practice?

24 A Refer to them? In -- in what --

25 Q Yeah. Do you reference the standards of care in

1 your daily practice?

2 A I practice consistent with the standards of care,
3 yes.

4 Q Is WPATH binding on all mental health
5 professionals?

6 A WPATH is a professional organization. I'm a
7 surgeon. So in my practice, as I said, I practice
8 consistent with the standards of care. I can't
9 hypothesize as to how all mental health
10 practitioners practice.

11 Q I guess what I'm getting at is there's no
12 requirement that a mental health professional
13 follow WPATH?

14 A You mean follow the standards of care?

15 Q Yes, the standards of care.

16 A You're saying is it a legal requirement?

17 Q Is it a medical requirement?

18 A I would say I practice consistent with the
19 standards of care, and the colleagues I know also
20 practice consistent with standards of care. I
21 can't opine on mental health practices. I'm not a
22 mental health professional.

23 Q Do all surgeons have to consult WPATH's standards
24 of care in their practice?

25 A So most of the surgeons I know also work consistent